

Interview with VADM J. William Cox, 28th Surgeon General of the Navy, 19 November 1993, conducted by Jan K. Herman, Historian, Bureau of Medicine and Surgery, San Diego, CA.

You grew up in Missouri, is that right?

Right. St. Louis.

Had you decided to be a physician early in your life?

I was always inclined toward something in the way of human service--pharmacy or medicine. I had decided to be a pharmacist and, as a matter of fact, was an apprentice pharmacist. At that time, you could attain licensure having studied under a registered pharmacist, and working very long hours. If you opened at eight in the morning, you got off at six. But if you came on at ten in the morning, you closed at eleven or twelve.

We lived in South St. Louis at the time, and next door to us was a group of very delightful women who were laboratory technicians. They had a party this particular night, and as I was coming in the back door at about midnight, one of the women came out and said, "Why don't you come over to the party?"

I said, "Oh, no. I'm just dead tired. Thanks for the invitation, but I've got to go to bed. I have to open in the morning."

She said, "No, come on over, even for just a little while."

So I went to the house. Their boyfriends were all V-12 medical students, and they couldn't understand why I wanted to be a pharmacist when I could be a physician. They persuaded me at least to apply to the university for entry as a pre-med student, which I did. I was accepted and went into pre-med, and that's how I managed to move on to become a physician. It was quite by accident.

Did you get a Ph.D. degree in pharmacology?

No, physiology. I guess that's interesting too, because that had never been done before. I was the first dual registrant as a graduate student in the Department of Physiology at the same time I was a medical student. What normally was a 4-year medical school or a 4-year graduate program could be compressed into a 6-year program by having concurrent registration. The second one to pursue that was Ted Cooper, who became Assistant Secretary of HEW (Department of Health, Education and Welfare) and had been Director of the National Heart and Lung Institute. He was a good friend of mine. So we were the first two that had combined dual registry in medical school and graduate school, leading to both the M.D. and the Ph.D. degree. I think it's commonplace now, but it wasn't then. We pioneered it.

It was interesting in those days. We were not told what our grades were until the very end of the course, and it was quite a ritual. It was a four-story building. They'd have the freshman class on the fourth floor, the sophomores on the third, the juniors on the second, and the seniors on the first. Father Schwitalla, who was a marvelous Jesuit priest but known as the "Black Fist of Medicine", was dean. He'd walk in with a little box of envelopes and would then start calling off names. The envelopes contained information telling if you were in a state of condition. This meant you had to take one of those courses over again in the summer, or that you had failed. But he was a little sadistic, and didn't go about it alphabetically, the way the envelopes were arranged. He'd go, "Alphonse, Abbott," and then skip one or two and put them at the back. So you didn't know until the very end if you had conditioned or failed.

I had no idea where I was in physiology at the time, but when I got home there was a letter at the door. I was number one in the class, and they invited me to become a graduate fellow and join the department, which I did. I normally would have had my M.D. in '51, but I got the M.D. in '52 and then the Ph.D. in '53.

I then took the position of Director of the Research Laboratories at the Veterans Administration Hospital at Jefferson Barracks. There was also a new hospital being built as the John Cochran Veterans Hospital in St. Louis. I had both those research laboratories and was equipping the new one when the Navy made the decision to accept me for my second internship. I had left the first internship because it was straight medicine and I didn't want straight medicine. I wanted to have experience across the board.

I left the Veterans Administration and entered naval service as an intern, rather older than most of them. When it was over, I got orders to the Montrose (APA-212). I was supposed to fly to San Francisco and catch an airplane out to pick up the ship in WestPac. I drew what we called dead horse, which was 3 months' pay. I was all checked out and went into the admiral's office to pay my respects and say my goodbye. And he said, "Where do you think you're going?"

I said, "I've got orders. I'm going to sea."

He said, "No, you're not."

I said, "But Admiral, I've got orders. I'm going to sea."

He said, "No, you're not. You go home, young man, stay put, and sit there until you hear from me."

So I didn't go to sea because I was teaching at that time. I was teaching those of the staff preparing for their boards, concentrating on those subjects particularly tailored to the various residencies, what we call the physiological sciences. That meant both physiology and pharmacology. They had double duty standard duties--carry out your practice but also do the teaching. And that's why they wanted me to remain there. So I agreed and remained.

In those days, the Dependent Service--it was called Dependent Service--was rather a sporadic catch-as-catch-can. It was poorly equipped, poorly organized, and really like a zoo. The then exec said, "Where would you like to work, Dr. Cox? What are your preferences?"

I said, "Sir, do I really have a choice?"

He said, "Yes."

I said, "Well, my order of preference, then, is Medical Service, Chest Service, destroyers, or OPD [Out Patient Department]." [Laughter] So I was assigned to the Medical Service.

That was absolutely the last thing in the world you wanted to do.

Yes. Well, anybody that lived or practiced in that era knew what a mess it was. It was before CHAMPUS. We were not manned to deal with the massive numbers of dependents. It was not a well-organized operation at the time. It subsequently became marvelously well organized, but not then.

So that began a long tour at the naval hospital. In '56, I accepted a position, deciding that I would stay, and I always tell people that I had made a decision over the years always in increments, 2 to 4 years. I never made a decision for 20 or 30 years, but only 2 to 4 years at a time. My attitude to the Navy was, as long as there was a challenge, as long as there was an opportunity, and as long as I was needed, I'd stay, and it really didn't make any difference where I went. So I drove detailers berserk. Across my preference card, I'd always put, "I'm happy where I am. I'll go where I'm sent."

I stayed from '56 to '59 in residency and fellowship and then '59 on the staff, and this is another interesting story. I went to see the chief of medicine at the time, CAPT Bruce Canaga, who had become a very good friend of mine. I told him "You know, Bruce, I've been here a long time. I came in '53, and this is '61. I'm sure they're getting very nervous back there in the detailer section that I need to go see the Navy and see the world. I've got a lot of irons in the fire with the teaching schedule and my relationship to the medical society, etc. I think I need to know in advance what's going on."

He told me that the admiral had just gotten back from a conference in Washington and that I was not going anywhere for at least another year.

I said, "All right."

I went down to the mailboxes in the officers' mail room, and there was my flimsy, "Orders to Subic Bay." Subic where?

They finally got you.

It happened that Bruce had been the senior medical officer at Subic prior to coming to San Diego, so he told me all the delightful things about the area and what an opportunity it was. At Subic Bay they did not have joint hospital accreditation. There was not a good record keeping system. What they had in mind for me was to design a record keeping system and first prepare the hospital for registry with the joint commission and then survey it for accreditation. With the help of CAPT Charles Root, we managed to get the institution registered and then surveyed and accredited.

After Subic, my obligation was up. I had enjoyed the Navy but I thought I'd leave the naval service. Bruce Canaga came out and said, "You can go anywhere you want to. You name it, and that's where you go."

He must have thought I'd say Bethesda or Oakland or San Diego, but I said Philadelphia. I had good reasons. There were five medical schools at Philadelphia. The Chief of Medicine was a good friend of mine from San Diego days, Leonard Jones, and I knew I could get along with him well, so I chose Philadelphia. And there I became director of the Division of Cardiovascular, Respiratory, Infectious and Metabolic Diseases. You know, a little bit of everything except the sick officers' quarters and the dependents ward.

We had a residency program. There was also a fellowship run as a separate service by CAPT Orville Nielsen, the GI Service. It wasn't too long after that that Len Jones and I began to explore the possibility of an affiliate relationship with the university medical centers. We had a consultants list that was the Who's Who in Medicine--Baccus in gastroenterology, Duncan in metabolic diseases, Billy Likoff in cardiovascular disease. It just went on and read like Who's Who. But we wanted formalized relationships, so we developed the program with a memorandum of understanding between the university medical center, the medical school, and the naval hospital that stands today. It started off with "We have this capability. You have this capability. We will do this. You will do that. And it could be mutually terminated on 30-day notice, and there would be no change of dollars, just personnel."

We became faculty members under an affiliate relationship with Thomas Jefferson University. We would teach students in the hospital. It started off with juniors, but then we also got the sophomores for physical diagnosis. Some of our staff would go over to their hematology unit. We began rotating residents into the Jefferson units for hematology, and they would send persons over for our experience. It became a very nice relationship. Well, this became institutionalized and moved on. When Don Custis became Surgeon General, he pushed it very

hard for Bethesda, and now it's all over the Navy, where there are very close relationships between naval hospitals with graduate training programs and with academic medical centers by memoranda of understanding.

Yet you were now again entering the administrative world at that time.

When Len Jones retired, he had previously been chief of medicine, and they appointed me chief of medicine. Orville Nielsen retired, and they reunited the GI Service with the Medical Service, so I then had the GI Service, as well.

There was another thing that Len and I started. I was always interested and had always done research, but there was a very difficult funding line. The RDT&E--research, development, test and evaluation--appropriation line, was exclusively for research in naval research laboratories. None of those dollars ever came to the naval hospitals directly, but supported the naval medical research units and the physiologic training units in aviation, the submarine underseas training in the submarine field, but not in naval hospitals.

So we developed the clinical investigation program in Philadelphia in close collaboration with the university and also with the Air Physiology Laboratory at the naval base in Philadelphia.

And you picked up responsibility for that, also.

Yes. So by the time I left Philadelphia, I was Chairman of the Department of Medicine, Director of Medical Education and Research, and headed the clinical investigation program.

In 1967, we had the first workshop in graduate medical education held in the National Capital area. I was invited to participate in that. I think at the time I was either a senior commander or very junior captain. It was an excellent conference, an excellent workshop, and they split us up into working groups. The one working group which I chaired and became the spokesperson for when we reported out to the flag officers had to do with the organization structure and the execution of residency programs. I was not shy, so I told them all what I thought was wrong with the graduate medical education programs administration and what could be done to correct it.

At that time the program directors had absolutely no say as to who was coming to their residency. They had absolutely no knowledge of when they were coming nor what their qualifications were, among other things. And then there was a tendency to remove people from their formalized training and send them on TAD here, there, and elsewhere.

Before they were finished?

Really before they were finished, so it was really good experience, but not totally educational and experience-based.

So anyhow, nothing was done. I went back to Philadelphia, and the same thing prevailed. In '69 was the second workshop in graduate medical education to which I was invited, and made my presentation and said, "I told you what was wrong with it before. It's still wrong with it. You haven't done anything about it, and here's what you could do about it."

So I got back to Philadelphia, and a phone call came, very nice and very polite, and I was being ordered to Washington to the education and training division.

And that was your first visit to BUMED.

Well, my first duty with BUMED. I went in to see Frank Norris, who was Code 3. That was the Assistant Chief of the Bureau for Personnel and Professional Operations. He was very

nice and very apologetic for dragging me out of clinical medicine, but it was only for 2 years. I said, "Yes, sir. Fine." So I bought a 2-year house.

I went to see Admiral Davis, George Davis. He and I had been close associates when he was the senior medical officer on sick officers' quarters here in San Diego back in the 50's, and I'd always had a great love and respect for George. He was apologizing for dragging me out of clinical medicine, "But it's only for 2 years." Of course, you know the story. It was 9 years later that I got humanitarian sea duty to San Diego.

As time went on, it evolved that the then head of Education and Training, Captain Rupnick, was assigned to command the Naval Medical Training Institute, which was the outgrowth of the old Naval Medical School, so called.

At Bethesda?

Yes. Well, it was on the Bethesda compound, but it was separate. At that time, it was a component command of the center.

When he was promoted to admiral and, I think, came back then as Code 3, I relieved him in command of the Naval Medical Training Institute. I had been serving on the Cagel Board, which established the Navywide directorate of Naval Education and Training and the Education and Training Command headquartered at Pensacola. I'd served on that board and thought that the unification of education and training under a central administration and a third-echelon command was a good system.

So I talked to then Surgeon General Don Custis, and Don and I had been close associates while he was Chief of Surgery at Philadelphia and I was Chief of Medicine. As a matter of fact, he was the originator of the concept of the executive council of a graduate training committee, which really put some governance and teeth into an appropriate oversight of training programs at the graduate level.

You were of a like mind as far as education.

Yes, very, very much of a like mind. He said, "Well, go ahead and work it up." So I worked up the precept for a board to establish a Navy Medical Education and Training Command. And one time I said, "This will never fly, Don. I'll put it on my nightstand." And I put it on my nightstand.

As he looked over the organization of the whole medical department of the Navy, he called me one time and said, "Bill, that precept for the board to establish a Naval Medical Education and Training Command, get it out of your nightstand and dust it off."

So I pulled it out of the nightstand, and he made Admiral Charlie Waite the chairman of that board, and they followed the precept and established the Naval Medical Education and Training Command. I'll give you three guesses who got to be the first commanding officer. So that's when I moved there.

As Commanding Officer I also had additional duty reporting to the chief of the Bureau of Medicine and Surgery as a special assistant for education and training. That was at the BUMED level. And then I also reported to the director of Naval Education and Training in the Pentagon.

So we had three echelons involved--echelon one at the Pentagon--the OPNAV level--echelon two at the BUMED level, and then an execution of a field command at the echelon three level. And that's how we brought all graduate education, nurse training, Medical Service Corps training and Hospital Corps training under one administration, one command.

How did it work from the beginning?

I think it went well. It had some growing pains and it had a lot of reluctant dragons, you know. You don't accrete authority to one area that had previously existed in another without considerable resentment and resistance, and that was there.

But it was also a good idea and it had to be, because we were then undergoing significant budgetary cuts. We would put the representatives of the various training programs into the conference room together and I'd tell them, "Come out when you've decided how best to assume these cuts." We decided to do it this way so the cuts wouldn't be across-the-board but rather would be a balance. This way the nursing training or Hospital Corps training wouldn't be decimated.

Continuing on with the story. We were in New Orleans. I served on the Board of Trustees of the American College of Cardiology and was in New Orleans for their annual meeting when a telephone call came to the headquarters booth in the exhibit hall for me to report to the telephone. Admiral Custis wanted to talk to me immediately. So I went there. He told me I had been selected for flag, which I really hadn't expected. I can assure you I hadn't expected it but was delighted to hear it.

We had a lot of our friends from Philadelphia and elsewhere there, so we threw a big party in the Blue Room at the Roosevelt Hotel that had a very nice dance band. The dance band was playing requests, so I went up to the band leader and I said, "Do you know 'It's a Wonderful World'?" This was at that time very popular a few years before with "Satchmo" [Louis Armstrong] the trumpet player, and it's now come back as a popular song. No, he didn't know it, but he had one he could substitute for it. So we were on the dance floor, and he starts playing "I Did It My Way." Well, everybody in that group was bound and determined that that's what I had requested, which I hadn't at all.

I then went to BUMED as Code 3, Assistant Chief of the Bureau for Professional Operations, and spent some time on that under Admiral Arentzen [Surgeon General]. These things are fascinating.

Admiral Arentzen is an absolutely marvelous person, just a delightful human being, but he had certain idiosyncracies. One of the most important was, you never told the man, "No, it can't be done," because if you did, you were dead. That was just a fact. What you had to do was go and say, "Okay, we'll take a look at it." Then you'd work out how it could be done, but then you'd point out to him what the consequences of doing it would be, the pros and cons and the outcomes. And some of them had outcomes that were not desirable. So he'd then rule them out and say, "We won't do that." But if you told him, "I won't do that" or "I can't do that," you would not get away with it. That was not the way to deal with him.

Actually, I had and still have a profound respect for Admiral Arentzen. When it came time to shuffle flags, he knew my love for my first duty station, which was San Diego, and assigned me to relieve Admiral Earl Brown, who was going to be surgeon to Commander in Chief, Pacific at Pearl Harbor. I spent 2 years here in San Diego.

That brings me to the next major thing. And that was convincing people in San Diego that Florida Canyon was the proper site for the replacement hospital. And it was such a simple premise. The maximum design for the new naval hospital facility would be marvelous for accommodating its responsibilities in a peacetime mode but totally inadequate to carry out its responsibilities in wartime. What you had to have was an emergency overnight expansion capability. Under emergency circumstances, this resided in Building 26 of the old hospital, a 1,000-bed surgical unit with 13 operating rooms. What I wanted for the replacement hospital

was all the technical attributes of a modern hospital but to keep Building 26 for use in an emergency.

Others wanted to build the new hospital on what they called Helix Heights, which was out in east San Diego, bounded by a cemetery and blocked in by a freeway, with no expansion capability at all.

This argument went back and forth, back and forth with nobody paying any attention to the argument. The emotions were running high. San Diego magazine put on its front cover a proposed new naval hospital, and it was an ugly giant monolith right in the middle of the park, which is nowhere near. We were building down in a canyon, where there were a few hawks and a lot of trash.

This battle was not won while I was in San Diego, but we made enough progress to make the persons who were powerful enough to block it come around. One day I decided to take a day of leave. I would wear civilian clothes and rent a dining room in a nearby central hotel. Then I would invite all the major players to lunch, and we'd have an informal discussion. I did that. I had the mayor's representative. I had Bea Evanson, head of the Committee 100 and the mother protector of Balboa Park, if you will. All the major players were there, including the chamber of commerce.

I said, "You know, we've got a senator, Gary Hart, who would love to have this authorization transferred to rebuild the Army hospital in Colorado." And I continued, "This hospital has got to have a plan to function not only in peacetime, but in wartime. If you think I'm going to hold still without objecting and have \$300 million of the taxpayers' money build a hospital that can't do its job in wartime, you've got another thing coming. My prediction is that the new hospital is going to be built in Florida Canyon alongside of Building 26 or it isn't going to be built in San Diego at all."

That broke it loose. The next day the opposition crumbled, except for the ones that were emotionally involved.

Tell me how you came to be Surgeon General.

I was invited to have an interview with Secretary Hidalgo when the position of surgeon general was to be filled. I can't speak highly enough about his integrity and his firm, gentle manner. His questions were clear and penetrating. I answered them honestly and departed.

There had been some type of selection process with additional interviews, I'm sure, hadn't there?

Oh, yes.

You had participated in that, but since you hadn't heard anything, you just dismissed it.

Yes. I assumed that it was somebody else.

I'm just curious for a moment. The actual selection process--

First of all, you have to be proposed by, I guess, the CNO [Chief of Naval Operations], in consultation with others. They have a long list. Then they look over the records, and come up with a short list. Those people are then invited back for interviews.

So you were interviewed by VCNO and then SECNAV?

VCNO, SECNAV, and Assistant Secretary of Defense.

So that had all transpired. Who was on the list at the time?

I don't know. You never know that.

You never learned afterward?

Well, you're better off not knowing. I know one or two because they told me. But it's best that once that decision is made, to accept and do the best you can and not let any professional competition cloud issues. So I never made any attempt to find out.

But at the time, the business of the siting of the new naval hospital still had not been settled. The civil engineers loved the idea of the simplicity of building on one of the alternate proposed sites and tried to persuade SECNAV that that was the proper decision. Some of the San Diego community were up in arms and didn't want it built in Florida Canyon.

What was the opposition to Florida Canyon by the community?

It was part of Balboa Park, and anything that's part of Balboa Park is sacrosanct. It doesn't make any difference whether it's a gulch or what.

I guess the other thing that I'm most pleased about was an award I received from the Department of Defense for advancing the cause of women in the military. I think one of the things that contributed to this is that I put a woman Medical Service Corps officer, a physical therapist, in command of one of our Hospital Corps Schools Command in Portsmouth, VA. In addition, Admiral Fran Shea, just before my appointment, had been selected to be the Chief of the Nurse Corps. I thought there was a major contribution that she could make. She was chief nurse when I was out here in San Diego, I'd watched her in action. I thought she was just a marvelous person, head screwed on straight, a real good administrator, as well as being an outstanding professional nurse. So I put her in command of the Education and Training Command, and then I brought her in as Code 3, where she was in charge of all personal and professional operations.

You also made some changes in the Hospital Corps. Were you the one who brought Steve Brown [HMCN Stephen Brown] in?

Yes. I think that had to do, though, with the establishment of the command master chief. I'm a little foggy on the details. But Steve was just an outstanding, dedicated person to whom the enlisted troops could really relate.

That was a marvelous choice. He was one of a kind.

Yes. He was a traditional person's sailor.

And yet had the education to back it up.

Right. But he talked their language, you know. They knew exactly where Steve stood, and he was as honest as the day was long and straight as an arrow.

There was the hospital ships issue.

Oh, yes. The hospital ships and the fleet hospitals. With the hospital ship issue, I guess it was Will Arentzen that really began that ball rolling. He had been commander of a hospital ship during the Vietnam War, and began pointing out the need for hospital ships again. Well, at that

time, the Assistant Secretary of Defense for Health was Dr. Jack Moxley. Jack had been Dean of the University of Maryland School of Medicine, was the youngest dean that had ever been appointed. Then he came to San Diego and was Dean of the University of California, San Diego School of Medicine, and from that position was selected as the Assistant Secretary of Defense for Health Affairs. Jack and I had become close personal friends, as well as close professional associates during his and my tenure out here. But Jack had fallen in love with the SS *United States*. The SS *United States* had the world's transatlantic crossing speed record. It had four screws. It was to be designed to have 2,000 patients, and I think 24 operating rooms. It was just a big monster. And besides that, you'd only have one hospital ship. My concern and strategic considerations for the future was that conflict would always be multi-focal. You know, they'd kick up their heels in Korea, or something would break out in the central front, and all at the same time. You really couldn't put all your eggs in one basket.

So Jack and I had considerable discussions about this, but I wanted four and he wanted one. Well, ultimately the decision was that the SS *United States* wasn't going to be the one, and I was fighting for four and finally managed to get two. But the interesting thing was, when the top-level requirements came out of the Naval Sea Systems Command, the old BuShips, the damn thing was going to cost more than an aircraft carrier, and I knew that if I went in--

For four?

No, one!

Just one would cost more than an aircraft carrier.

I knew that if I walked into CNO's office with top-level requirements for a ship costing more than an aircraft carrier, that he would not only say no, he'd throw me right out the sixth-floor window. So we scaled that back. We took the liquid oxygen plant off among other cost drivers.

The original top-level requirements had called for a simultaneous offloading and onloading of patients. It could receive casualties by helicopter and by water surface simultaneously as they were offloading patients that no longer required hospitalization, by both helicopter and water surface. So we took a number of expensive niceties, you know, that are important to have, but the cost goes up for a small increment of capability, and we had to scale that down.

Where did the big push for hospital ships come from? Did it come from DoD?

No. The big push for the hospital ships started with Will Arentzen and then was picked up by ASD Health Affairs and aided very strenuously by Commandant Marine Corps.

The line was not tickled at all. Obviously, it was going to take away from their ship program, and they wanted the combatants. As far as I can tell from the documentation, they did everything they could along the way to throw up roadblocks.

They managed to throw up quite a few. [Laughter] But we managed ultimately to convince CNO and the CNO's executive board that it was necessary, and this was done with the validated 2104 scenario contingency based on casualty experience of World War II, Korea, and the early part of Vietnam, all fought with conventional weaponry. The scenario said that without hospital ships and/or a fleet hospital, in an opposed amphibious assault, within 10 days no longer

would you have an effective fighting force because of loss of Marines to the evacuation chain instead of treatment in theater and then returned to duty. So it took a lot of convincing.

Incidentally, the current Surgeon General, [VADM Donald Hagen] had a lot to do with these studies. He was Director of Contingency Planning while I was SG, and his predecessor was Lou Eske, who is now deceased.

Eske was also involved in the fleet hospital program.

Right.

How about the two tanker hulls?

Well, that was undoubtedly a Sea Systems Command decision. That was technical to take those and convert them within budget. We did what the medical requirements were, and how they were accommodated and designed was up to Sea Systems Command.

But rather than getting the four ships that you wanted--

We got two.

In other words, "This is what you're getting, so like it or not."

Right. Well, at least it was better than one. And, as you know, we've got one on the East Coast and one on the West Coast, and you can send them both to the same theater, as we did, or you can send them to separate theaters if you need to.

But your original idea, your original four-ship hospital idea would still even today be a better deal. It would make a lot more sense even now.

But it had to do with affordability and relative priorities.

While this was happening, you had the fleet hospital program. How did that proceed?

This was moving with less resistance because of an intense support of the concept by the Marine Corps. It had to do with recognizing the fact that what had heretofore been adequate in an evacuation chain was no longer adequate. In modern warfare with high-velocity missile wounds and so forth, you had to have that in order to maintain combat sustainability of the Marine force. The fact that the fleet hospitals were containerized, deployable, relocateable, all had critical importance. I don't recall anywhere near the opposition by the components of the line to the fleet hospitals as there was to the hospital ships.

I must give credit to the one that really started the ball rolling and pushed, pushed, pushed for the fleet hospitals, and that's Rear Admiral Al Wilson. Granted, I brought it to fruition, but it was Arentzen that began the push for the hospital ship and Wilson that began the push for the fleet hospitals.

I think those two individuals were at each other a lot, if I remember. They had--
Differences of opinion.

Differences of opinion, yes. I remember at one point I think Admiral Arentzen took Admiral Wilson off the project for a while. He put--I'm trying to remember who it was. Admiral Lowry?

Yes, Clint Lowry.

Put Admiral Lowry on for a bit. But then I think eventually Admiral Wilson went back to the project. I don't know what the machinations were there.

Al was a surgeon, of course, and had extensive combat experience. Al Wilson was Chief of Surgery when I went to Subic, and I followed and knew him and his career for all those years. So he knew what he was talking about in many instances. But as is often true of somebody who knows what they're talking about, they get very firm in their views and very firm in their opinions and very unyielding in their conviction, in which circumstances they forget that there is more than one way to skin a cat. I know none of the details, but I think Al was firm and set in his ways about what the fleet hospital program ought to be, and I think Will had another approach. And after all, Will was the Surgeon General.

But they proceeded, and, as you say, roadblocks were mostly thrown up in front of the hospital ship program. I think it was more obvious to the line that their money was going into something they really didn't want. The Marines wanted it, but the line Navy was--

There's another interesting story of how things come around. From World II through the Korean War to the Vietnam War, the medical materiel of the organic units of the Marine Corps had just been totally cannibalized. There was a sizable amount of money--I can't remember how many millions--put into the Marine medical battalions. Then we called them MAF, Marine Amphibious Forces, rather than what they're called now.

The Marine Corps general on the West Coast that had the Field Service and Support Group, Commanding General of the FSSG, was Robert Habel. I marveled at his ability to draw plans, receive material, sort it, get perishables up front where they could be rotated out into active use, and replace it without making a federal case out of it. Such materials included things like antibiotics and certain other drugs. He was responsible for having a 10-day supply of these things packaged in the mount-out blocks and the resupply blocks. He had to draw up plans for their arrival and their distribution for any given scenario. All this was just an exceedingly complex issue, and he did it, to my estimation, in an absolutely effective way.

The next I heard was that General Habel was commanding general of Camp Pendleton. He came down to San Diego County to speak at a nuclear disaster seminar and was excellent in his presentation. He was a close friend of our then chief administrative officer for the county, Norman Hickey, and after he retired, Norman brought him into my office. He was interested in possibly doing something with the county in his military retirement years. I turned his CV and interviews over to my senior staff and stayed out of it. They fell in love with him, not only with his ability, his history, and his record, but his personality. And he became my assistant deputy director for Public Health, and is still in that position.

In the county?

In the county.

If I remember correctly, there seemed to be more antipathy between the Medical Department and the line during 1981 and '82. Things were deteriorating. What was going on?

Everything that epitomized the statesmanship and the reasonableness and the wisdom of Secretary Hidalgo was lost when Secretary Hidalgo left. I won't go beyond that, other than the fact that I was never called in to consult with the new Secretary of the Navy [John Lehman]. He "knew everything," so he didn't need to hear anybody else.

The Navy was essentially his toy, if I remember correctly.

Yeah. Let me put it this way. The then CNO--

[James] Watkins?

Yes, but [Carlisle A.H.] Trost. Watkins' successor. [Tape recorder turned off]

Philadelphia's gone. The fleet dispersal system is gone. I'm thinking in terms of all the money that was spent on the homeport idea--Staten Island. The battleships are mothballed. So all of those ideas have essentially disappeared. But we were forced to undergo a reorganization. That was the doing away of BUMED and establishment of the Naval Medical Command in '82.

Right. The concept of geographical or regional commands in a central headquarters command has precedent, and if adequately supported and staffed, it would have worked. But what happened was that there was minimum essential staffing of the geographic commands and the staffing of the Headquarters Command was taken out of the hides of the talent of the hospitals. They literally raped the hospitals to establish those and never established new billets or new numbers to carry out a regional geographic and a central command structure.

Where did the regionalization idea come from? Didn't that begin with the Naval Regional Medical Center concept?

Yes, that was started in, I think, [VADM Donald] Custis' time.

That was still in existence?

That was still in existence. But what had happened is that they thought the span of control was too great and that there should be somebody simply running the hospital, somebody simply running the clinics, and then there would be a support or management structure over that. The only way to reasonably have done that would have been to establish geographic commands, where you took horizontal, as well as vertical, integration in a given geographic region. It's a sound principle of management, but you have to bite the bullet to pay for it. You have to staff it.

Where did the original initiative come from for that?

The push came out of the Secretary's office, through the Assistant Secretary or the Under Secretary, down through the Vice Chief, that something had to be done to reorganize. Anytime something is in trouble, financially or otherwise, it's standard operating procedure--reorganize.

So they did it, and it didn't work. It was an 8-year experiment that fell apart.

Yes. And the reason it fell apart and didn't work is that they never followed through on providing the adequate staffing that was required to do it. They continued to reduce the level of support and increase the demands.

As you recall, wasn't there a great deal of hostility directed at the Medical Department? Was that hostility coming out of the SecNav's office? Where was it? Was it generalized?

I think most of it came out of the secretariat down through the VCNO [Vice Chief of Naval Operations] and was pushed. And, of course, whenever the leadership takes that kind of attitude, the rest tend to follow. There never was a great love of the Medical Department by the line, in general, particularly the air and the submarine side of the house. The black shoes, to a degree, appreciated what the Medical Department did. Certainly, the amphibious task force commanders did, but the real support and knowledge of the Medical Department came from the Marines.

They've always appreciated it. But the line Navy always showed some antipathy which built into a hostility in more recent times.

No, this goes back to the days when the predecessor of the Chief of Naval Operations resigned when Teddy Roosevelt insisted that a commander of the hospital ship be a physician. This dates back to the very early 1900s. In recent years that hostility was aided and abetted because of the secretariats.

And after you left, it built to a fever pitch. I recall that they took Admiral [Lewis H.] Seaton out of the Bureau and stuck him over in the Pentagon. I remember talking with him at that time, and I think he said that he was under house arrest. I believe that was the terminology he used to describe what had happened to the Medical Department.

Yes, he literally commanded his desk and little else.

Yes. They stuck him in an office with a tiny window. And I remember he said later on that he was now working directly for CNO, and yet CNO wouldn't see him.

The CNO I was thinking about before was Carl Trost, and I will quote this, because after the Secretary left office, it appeared in the newspaper with a quote from Carl Trost, "Good riddance. He was unbalanced." My reaction was, "Carl, when I was having all my problems with him, where the hell were you?"

He was retired at that point?

Yes.

Trost had retired. He wouldn't have said that if he were on active duty, obviously. There were other things going on at the time. When you took over the Bureau, were you were aware of all this or did some of it come as a surprise?

Having been somewhat a superficial student of naval history, I was not the least bit surprised. Any organization that has the heritage and the tradition and the lineage that the United States Navy has is going to have certain hidebound attitudes that become entrenched over the years. I knew about the hospital ship issue. I knew about the attitude of the father of nuclear submarines toward medics. You know, I didn't walk in like a bright-eyed, bushy-tailed young man. I knew it was going to be a tough job.

Were there any real surprises?

Not really. Not really. No. I'd been around. I'd been in university centers, I'd been in major hospitals, and I knew the give and take of ambitions and antipathies, the principle that if you don't know something about something, your tendency is to either fear it, oppose it, or ignore it.

You take bright-eyed, bushy-tailed, brilliant young men, put them through the Naval Academy and then put them through master's and doctoral degrees in physics and nuclear physics. Then put them in command of multibillion-dollar entities and pump up their egos. They don't know anything about medicine. They've never been sick. They're young enough when they start out that they don't see any need for it. "What's all this?"

We had one devil of a time convincing them of the need for the manning levels of the fleet hospitals. They thought a doctor is a doctor is a doctor. I think the classic example was in the reserve component, where the commanding officer of a surgical mobilization unit would be a psychiatrist. You know, that's idiocy.

If they need a surgeon.

Yes. But they just plugged in a doctor, assuming that a doctor is a doctor, and that had been going on for years. Marines, on the other hand, have seen it. They know what the corpsmen do. They know what the physicians at the battalion aid station and the clearing and collecting companies have done.

That's been fairly traditional. The Marines have always been supporters.

Yes. But you see, it's come back to what I said. If you don't know something about something, there are three reactions. Sometimes you do all three. You fear it, you oppose it, or you ignore it.

Was the Medical Department blameless in all of this?

No, of course it wasn't blameless.

I only bring this up because I recall having a discussion with a neurosurgeon assigned to the *Nimitz*. Apparently, he had a reputation as a complainer, "What am I doing out here on this carrier? My special skills are not being used." And he complained to the wrong people. He complained to his line buddies. I had talked to some of them, and they said, "Oh, yeah, we got that doctor in the medical department who does nothing but complain and moan about being out here away from his family. We're away from our families."

I began to think about that and thought to myself there was going to be a time when these line officers were going to be in a position of power, and they were going to remember a complaining doctor, or perhaps a group of them, and were going to be in a position to do something nasty to the Medical Department, and I'm wondering whether this had something to do with it.

Probably not consciously, but subconsciously it makes a major contribution. And, yes, you hit right on it. When I was pulled out of a very big fish pond at San Diego, and sent to a station hospital in the Philippines, I didn't want to go, because I was spoiled. But I made no bones about it. That time in the Philippines at that hospital was the most important component of my entire 30-year professional career in the Navy. All of a sudden, I looked around and said, "My God, I'm it--ENT, endocrinology, cardiology, neurology, psychiatry. I'm sole source!"

You begin to realize very quickly that not all the world is Balboa Naval Hospital or Bethesda Naval Hospital or Mount Sinai or Massachusetts General. It was interesting to me when I would receive people out there, Berry Planners who had been deferred to get their specialty, they came out often times as prima donnas. And when I'd get a person that had been permitted to have one year or maybe 2 years in residency training, because they staggered it at that time, they'd come out, they'd get into it, they'd make their contribution, and it was just as important in that setting as it was for the neurosurgeon in his setting.

Once they were exposed to it, some of them--

If you do it early enough. But first of all, as an individual--I liked the idea. I opposed it when it was originally proposed, and then the more I saw of it, the more I liked it, and that was the all-volunteer force. Of course, now the medical school, which is under fire, needs to be preserved. You can tell these people point blank what is going to happen: "You are going to sea, you are going with the Marines, and there are no ifs, ands, or buts about it." In my estimation, there should never be an exception to a requirement for a tour of sea duty, overseas in a small establishment, or a tour with the Marines. There's no substitute for it. And then you know that you've got to understand and appreciate the fact that it doesn't make any difference what your specialty is, that there are requirements and billets with the Marine Corps that have to be filled. And if you're a pediatrician, there's a mobilization billet for you. You better know what it is and what it requires.

I think a good example of this is one of the younger flags there now, Noel Dysart. He's a super subspecialist. He's a pediatric nephrologist. And look at his contributions and his experience with operating forces. Take a look at it.

Did you ever feel like you missed out by not going to sea and going with the Marines?

Sure. Sure. As a matter of fact, at one time I had made application for both. Being a physiologist, my plan was to go through the School of Aviation Medicine, which would, of course, put me on a carrier. But I also wanted to go through the School of Submarine Medicine, which would have put me on a submarine. But they wouldn't let me do that. "You can't do that." "What do you mean, you can't do that?" Now we do it. We've got dual trained people. And that was another thing that I pushed, was dual training.

We have them, too. And we had them. In the mid-'80s I remember seeing wings and caduceus.

Well, I was trained to be the commander of the First Medical Battalion and had gone through all the amphibious warfare training. But again, the needs of the Navy dictated a different path.

Your orders to the APA that were canceled, there's a good example.

Right. I'd already checked out.

You had yourself pretty well conditioned and psyched for that assignment, and then they decided your talents were needed in another area. I'll tell you, from the period I remember, I remember the early '80s and I can remember the feelings of sadness and outrage at the Bureau when you left. Many of us felt that you deserved to be there, we

wanted you there, and whatever happened, we didn't know the details of it, but we felt it was a terrible thing. And there are people who are still there today who feel that way. I know I do.

Well, you know, at best it would have only been one more year, but it got to the point where I simply could not continue to tolerate the ignorant interference with the management of the department that was emanating from the Secretary's office. It was just unacceptable. He had other plans that I found so totally unacceptable that I went to CNO and told him what the several things were--I don't even remember the details of them now--and said, "You've got to stop that man. And if you don't, I'm going public." He said he'd stop him. I said, "Fine. Request permission to go ashore." Because I'm also convinced that when you have somebody that's in an appointed office that is designated as your senior, your superior, you either support him or you hang up your suit and go someplace else and do something different. And it got to the point where I could no longer support the approach of the Secretary, and I was getting no backing from the line. They were aiding and abetting the Secretary, so I just had to go ashore.

They were getting what they wanted. They were getting more ships, the 600-ship Navy. They were getting more aircraft. I guess the staff people like to call it the line's toys. They were getting very expensive toys. I mean, let's face it. If you're a line officer, a ship driver, what's the best thing you can have? Another frigate or another--and they were building ships and, of course, bringing the battleships out of mothballs and retrofitting them. And if you wanted to play, you had all the toys you wanted to play with.

The only thing is, you didn't have the personnel to staff them. That's the other thing that they didn't provide for in the 600-ship Navy. If you go back over the proposed force structure, there was never an adequate number of people to man a 600-ship Navy.

How did you feel about the Medical School [USUHS]?

For years, this school been proposed by Congressman Edward Hebert from New Orleans and was advocated by a number of important people, but never considered a wise investment or a necessary endeavor on the part of the Navy, or for that matter, of the Department of Defense. But as I understand it, Congressman Hebert, when he became Chairman of the House Armed Services Committee, as politicians are wont to do, more or less told the hierarchy of naval service and DoD, "You support my University of the Health Sciences, or some other things you want will not be supported by me," among which were the military construction budget, the ship construction budget, the missile budget, bonuses for physicians. That's when they were totally unable to retain an adequate number of physicians by virtue of the absence of a suitable financial return. And he managed to turn that around.

The interesting thing was, I don't know whether George will remember it, but one day he called me into his office and said--

George Davis?

George Davis. He said, "I want you to develop a list of pros and cons relative to the Department of Defense medical school."

So I went home that night. I used to use baby-blue ink on things that I wrote, and I wrote this out and I think I had one or two pros and a page and a half of cons. I took it into George and he took one look at it. He knew what was going on with Hebert. I was a neophyte. I didn't

know what was going on there. He said, "I want you to take this out and burn it, and I don't mean on the Xerox machine."

There were obviously a lot more cons than pros, as far as you were concerned.

Yes, initially. But once it was established and they began hiring tenured faculty and had a perfectly appropriate long-term commitment. You see, the obligation of those 4 years of medical school was 7 years of active duty, as I recall it, in other than training. So if you took a residency and compounded the obligation of 2 years for the residency, you took the individual-- maybe it was 5 years of obligation. I can't recall, either 5 or 7. But let's say it was 5. If it was 5, plus 3 years of residency is 8, plus 2 years of obligation for the residency is 10, plus 4 years of constructive credit toward your retirement eligibility in terms of pay.

You've got them.

Yes, you've got them! As it was argued at the time, they are the "core of the corps." These people aren't going to be prima donnas complaining about their sea duty or their tour of duty with the Marines. They've been through the C-4 course. They knew they were walking when they started. They're told up front. They know they've got this long-term commitment. So why not make the most of the opportunities?

Once it was established, then--

Then I'm a firm supporter of it. As a matter of fact, through the National Medical Veterans Society we have a multiplicity of authors for a resolution which will be presented as an emergency resolution in the December meeting at New Orleans of the AMA.

Which will be welcomed by Vice Admiral [James A.] Zimble. I had a chat with him the other day.

Does he know it? Has he seen the--

I don't know if he's seen that. But I was asking him the situation. I was asking him if he was going to be testifying, and he said the biggest problem that he has right now is that the school is on the list for closure. He said, "We can run another year, but now OMB [Office of Management and Budget] is playing games, cutting the budget for the next year. I don't know how we're going to operate."

Again, if you don't understand it, you fear it, oppose it, or ignore it. Well, I'm hoping that this resolution will pass, because before it was established, the AMA was on record as opposing the medical school. Then we got the AMA to take a neutral stand after it was once established. I think we'll be able to persuade the AMA this time that it is established and it is functioning; it is serving its purpose. There is no other source for a physician that you know you've got committed for 10 years or more. We will be fighting for passage, and there is a very broad-based authorship of the resolution to support continuing the medical school.